



Request for Prior Authorization
LINEZOLID (ZYVOX®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that: Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable), AND Patient has an active infection and meets one of the following diagnostic criteria: Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy, Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin, Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin.

Preferred

Non-Preferred

Linezolid

Zyvox

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

- Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy
Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin\*\*
Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin\*\*
Other (specify):

Is Prescriber Infectious Disease (ID) Specialist? Yes No If no, note consultation with ID Specialist: Consultation Date: Physician Name & Phone:

Pertinent Lab data:

Additional relevant information:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.